STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

0 4 0 0 7

SUBMITTAL IDENTIFIER (SID): ARKANSAS 04-07

TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE May 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

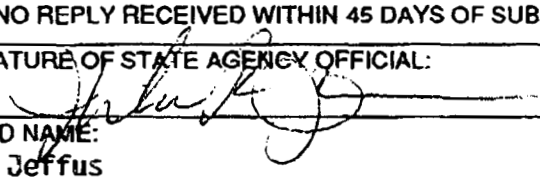
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 430	7. FEDERAL BUDGET IMPACT: a. FFY 2003 $ -0- b. FFY 2004 $ -0-
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Please see attached listing	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Please see attached listing

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to change HCFA to CMS and make other minor corrections to be consistent with current policies.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Division of Medical Services P. O. Box 1437 Little Rock, AR 72203-1437 Attention: Joie Wallis Slot S295
13. TYPED NAME: Roy Jeffus	
14. TITLE: Director, Division of Medical Services	
15. DATE SUBMITTED: April 15, 2004	

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17. DATE RECEIVED: 20 APRIL 2004	18. DATE APPROVED: JUN 24 2004
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY 1 2004	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: ANDREW A. FREDRICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV. OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

FORM HCFA-179 (07-92)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES Revised: May 1, 2004

1. Inpatient Hospital Services (Continued)

Arkansas' method of reimbursing malpractice insurance will be a simple calculation made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report.

For those hospitals determined as rural hospitals as of January 1, 1989, the base period for determination of TEFRA limits will be the first full cost reporting period beginning on or after January 1, 1989 – inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional Set Inflation Factor).

For all other Arkansas acute care hospitals, with the exception of Pediatric Hospitals and Arkansas State Operated Teaching Hospitals, the base period for determination of TEFRA limits will be the first full cost reporting period beginning on or after July 1, 1991. The inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional Set Inflation Factor) will be applied beginning the first year after the base year. Thereafter, the TEFRA limit will be updated annually using the CMS Market Basket Index or the Congressional Set Inflation Factor.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: May 1, 2004

1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

(a) Extraordinary Circumstances. The hospital must demonstrate to the State that it incurred increased costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to strikes, fire, earthquakes, floods or similar unusual occurrences with substantial cost effects. For the above circumstances, the TEFRA limit would be waived for the cost reporting period in which the extraordinary circumstances occurred. The TEFRA limit would be applied for the next cost reporting period with the current inflation factor and the preceding year's inflation factor applied.

(b) Changes in Case Mix. The hospital has added or discontinued services in a year after its base period or has experienced a change in case mix. Also, the addition or discontinuation of a new hospital unit(s) such as, but not limited to, a new burn unit or psychiatric unit could result in a change in case mix. The hospital must demonstrate to the State that the change in case mix resulted in a distortion in the rate of cost increase and the hospital must submit data to the State summarizing the case mix changes and the resulting changes in costs. The TEFRA limit will be adjusted to reflect the increase in cost for the year that the change in case mix occurred.

1.b. The Medicaid per diem will be subject to rate of increase granted under Medicare to PPS exempt hospitals.

1.c. If the provider does not qualify or apply for the exception, the base period (TEFRA Year) will be the initial cost reporting period when the hospital enrolled as a pediatric hospital in the Arkansas Medicaid Program. The inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional set inflation factor) would be applied beginning the first year after the base year.

1.d. Physicians/Administrative/Teachers will be included in costs as recognized by Medicare reimbursement principles.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES Revised: May 1, 2004

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(b) Effective with cost reporting periods beginning on or after July 1, 1993, direct medical education costs, including graduate medical education, will be reimbursed using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rule will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments.

Effective for cost reporting periods beginning on or after January 1, 1997, Arkansas Medicaid will begin excluding graduate medical education (GME) cost from the interim rate. A separate payment for GME reimbursement will be made quarterly and will be calculated based on the number of paid days for that quarter, arrived from the Medicaid Management Information System, multiplied by the GME reimbursement per day determined by the previous cost reporting period. A reimbursement settlement for GME will be made at the time the cost settlements are processed. The GME reimbursement will be calculated using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rules will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments. GME payments will not be subject to the upper limit.

(c) The base period for the determination of the TEFRA limit will be current year which is the fiscal year ending immediately prior to the first period this change goes into effect. EXAMPLE: The University of Arkansas for Medical Sciences' (UAMS) base period for determination of TEFRA limits will be fiscal year ending June 30, 1989. Only inpatient operating costs are subject to the limit.

Arkansas Medicaid will use the CMS Market Basket Index or the Congressional Set Inflation Factor for hospitals not subject to the Medicare prospective payment system.

Effective for cost reporting periods ending on or after June 30, 2000, the TEFRA rate of increase limit will no longer be applied to Arkansas State Operated Teaching Hospitals.

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Revised: May 1, 2004

2. Disproportionate Share Payment (Continued)

If the total of all disproportionate share payment amounts for all disproportionate share hospitals (acute care, inpatient psychiatric, rehabilitative hospitals and border city hospitals) exceed in any given year the federally determined disproportionate share allotment for Arkansas, the disproportionate share payments will be reduced proportionately among disproportionate share hospitals to a level in compliance with the federal disproportionate share allotment. Cities which are located within a fifty (50) mile trade area are considered bordering cities. **See list of bordering cities in Attachment 4.19-A, Page 3a.**

Rate Appeal Process

Participating hospitals are provided the following mechanism to appeal their disproportionate share eligibility and/or rate.

A. All hospitals will be notified of their eligibility status for the disproportionate share payment and of this disproportionate rate, by certified mail. A hospital administrator may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services.

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3. Additional Disproportionate Share Payment

Effective April 5, 2001, the total annual Disproportionate Share Hospital (DSH) payments to all qualifying hospitals (acute care, inpatient psychiatric, rehabilitative and border city), as calculated per Section #2 of Attachment 4.19-A, is capped at a maximum annual total of $2,745,367. This maximum annual DSH total does not include the additional DSH amounts payable to Arkansas State Operated Psychiatric Hospitals and Arkansas State Operated Teaching Hospitals as identified in this Section. The DSH payment to each qualifying hospital will be reduced proportionately if the total of the individual hospital DSH payable amounts exceeds the annual $2,745,367 maximum.

Effective April 5, 2001, the Arkansas State Operated Psychiatric Hospitals shall qualify to receive an additional DSH amount. Arkansas State Operated Psychiatric Hospitals are classified as a separate class group for DSH purposes. The Medicaid DSH definition of a State Operated Psychiatric Hospital is a psychiatric hospital that has in effect an agreement to participate in Medicaid as an inpatient psychiatric hospital and is operated by the State of Arkansas. The additional payable amount is the difference between the annual State DSH maximum amount for psychiatric hospitals (Federal plus State Share) and the DSH payable amounts to all psychiatric hospitals as calculated per Section #2 of Attachment 4.19-A. The State Operated Psychiatric Hospitals must qualify under either the Medicaid inpatient utilization rate or low-income utilization rate methods and must meet all other requirements of Section #2 in order to receive the additional DSH reimbursement. The State DSH maximum amount for psychiatric hospitals is identified annually by the **Centers for Medicare and Medicaid Services (CMS)** and is included in the federally **(CMS)** determined annual State DSH allotment. If qualified, the State Operated Psychiatric Hospitals are reimbursed both the DSH amount as calculated per Section #2 plus the additional DSH amount. Arkansas State Operated Psychiatric Hospitals are provided the same mechanism to appeal their additional DSH payment eligibility and/or rate as is identified in Section #2.

Effective April 5, 2001, the Arkansas State Operated Teaching Hospitals shall qualify to receive an additional DSH amount. Arkansas State Operated Teaching Hospitals are classified as a separate class group for DSH purposes. The additional payable amount is the difference between the annual DSH allotment amount (Federal plus State Share) and the total other DSH payable amounts, including all amounts payable to the State Operated Psychiatric Hospitals. The State Operated Teaching Hospitals must qualify under either the Medicaid inpatient utilization rate or low-income utilization rate methods and must meet all other requirements of Section #2 in order to receive the additional DSH reimbursement. The State DSH allotment is identified annually by the **Centers for Medicare and Medicaid Services (CMS)**. If qualified, the State Operated Teaching Hospitals are reimbursed both the DSH amount as calculated per Section #2 plus the additional DSH amount. Arkansas State Operated Teaching Hospitals are provided the same mechanism to appeal their additional DSH payment eligibility and/or rate is identified in Section #2.

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